

WV TBI Waiver MNER Instructions

INSTRUCTIONS FOR MEDICAL NECESSITY EVALUATION REQUEST FORM

Check initial if this is the first MNER completed for an applicant.

Check reevaluation if the MNER is for an enrolled member in the TBI Waiver Program due for a reevaluation. The completed MNER for reevaluation is due forty-five (45) days prior to the member's enrollment date. Initial and Reevaluation MNER are faxed to APS Healthcare (secured fax line) at 866-607-9903.

Please Note: The required signatures must be on the form, documentation of verbal orders or consent is not acceptable and the MNER will not be processed, until all required signatures are on the MNER.

Applicant/Member Section

Please fill out the following information:

- Applicant/Member Name
- Applicant/Member Social Security Number
- Applicant /Member Physical Address
 - Must be facility address for an initial applicant
 - Check type of facility for initial applicant and provide phone number, fax and name facility contact person
- Applicant/Member Mailing Address
- Applicant/Member Phone Number
- Applicant/Member Gender (please circle)
- Applicant /Member E-Mail (if applicable)
- Applicant/Member Date of Birth
- Applicant /Member Medicaid Number, Medicare Number and any other Health Insurance

Legal Representative Section

Please check if the applicant/member is his/her own legal representative.

If the applicant/member has a legal representative please check off the representative's relationship to the applicant/member.

Fill out the legal representative information in the designated areas with the following information:

- Representative's Name
- Representative's Phone Number
- Representative's Mailing Address

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Applicant/Member/Legal Representative Signature

Have applicant/member or legal representative sign in order to verify all information listed in the MNER form is accurate. The applicant/member and/or their legal representative must sign the MNER form in order for it to be approved.

Case Management Agency (Reevaluations Only)

If MNER is being completed for an existing member due for reevaluation, please fill out the following information:

- Case Management Agency Name
- Case Manager Name
- Agency Address
- Agency Phone Number and Fax

Referring Physician Information

Please list the following information regarding the referring physician (M.D. or D.O) or specially trained neuropsychologist:

- Name of Referring Physician
- Phone Number and Fax for Referring Physician
- Mailing Address of Referring Physician

Please list of Applicant/Member's Diagnoses (must include any/all TBI diagnoses) in the designated section, as well as any accompanying ICD-9 Codes found in applicant/member medical record.

Check off any functional deficits the applicant/member exhibits due to his/her TBI, causing assistance to be needed. Once completed, the MNER form will need to be signed by the referring physician. The signature of the referring physician must be on the MNER form in order for the form to be approved. This signature is valid for 60 days.

Upon MNER completion with physician signature and date, the MNER can be mailed or faxed to APS Healthcare, Inc. at the listed address and/or fax number. Any additional questions can be addressed by calling the number listed at the bottom of the MNER form.